

## Massachusetts Health & Homeland Alert Network

The Massachusetts Health & Homeland Alert Network (HHAN) provides secure web-based communication and information-sharing capability for the Commonwealth. State government agencies and cities and towns use the HHAN in support of emergency and bioterrorism preparedness efforts. This support includes, but is not limited to, emergency alerts, response planning, educational services; and, in the future, disease surveillance, laboratory reporting, and epidemiological investigation.

The HHAN continues to grow, with 3500 registered users from state and local public health agencies, emergency management agencies, community health centers, fire services, emergency medical services, hospitals and law enforcement. More join every week

The HHAN is decentralized and depends on users being trained, informed and involved. For the trained individual user, this mostly means keeping their profile up-to-date when address or phone number changes, or adjusting the alerting profile when unavailable. For an organizational HHAN administrator, participation is more involved; for example, assuring users are maintained in their proper roles and routing documents along approval paths.

HHAN staff is available to teach how to use the HHAN and how to get the most out of this powerful tool. Do you need a way to contact and distribute information quickly to 60 volunteers for your emergency dispensing site? Are you having a hard time keeping your call-down list accurate? Would you like to see how other boards of health are planning to handle casualty scenarios? The HHAN was designed with you in mind and can help you craft local solutions while integrating you into the nationwide response plan.

If you are new to the HHAN or if you're just rusty in it's use, don't worry. The Massachusetts Department of Public Health (MDPH) continues to offer training options for new users and refreshers. HHAN classes are offered at sites in Holyoke and Jamaica Plain. Typically there is one class, at each site, every month. If these classes are convenient and you need training for yourself and perhaps a couple of others, then this may be your best option (call the telephone number at the end of the article for a class schedule.) However, if you need 15 or more people trained, HHAN staff will come to you. Most computer

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## STD/HIV Prevention Training Center of New England

The STD/HIV Prevention Training Center (PTC) of New England is one of ten sites funded by the Centers for Disease Control and Prevention (CDC) to provide clinical training and information for health care providers in the diagnosis, treatment and management of sexually transmitted diseases and the prevention of HIV infection. The training center is part of the National Network of STD/HIV Prevention Training Centers (NNPTC), a vital resource providing clinical, behavioral, and partner management information and education for health professionals.

Since 1995, the PTC of New England has reached thousands of clinicians and laboratorians with up-to-date information on STDs. THE PTC was able to reach a broad group of new and experienced practitioners in correctional health care, school-based health centers, college health, private health care and other settings where they diagnose and treat STDs in adolescents and adults. Courses are designed to meet the needs of the busy clinician; assessments are conducted on an ongoing basis to elicit practice challenges, training needs, and ideal training modalities. Over the years, course content and training formats have changed to meet identified needs. For example, in recent years, educational resources via the Internet have been in increasing demand; in response, the PTC has developed several web-based modules, accessible for self-study.

Course offerings include laboratory training in conjunction with the National Laboratory Training Network (NLTN), intensive multi-day trainings in partnership with local STD clinics, and on-site "Grand Rounds" lectures. To meet the demand for training in Connecticut, the PTC also collaborates with the Hartford Health Department and offers training in Hartford on a regular basis. Laboratory courses are held at the State Laboratory Institute and include wet mount, Gram stain, and syphilis serology courses. The cornerstone of the program is a three-day intensive course offered at three training sites: Mass General Hospital, Boston Medical Center, and the Burgdorf/Fleet Health Center in Hartford. Intensive trainings are a combination of didactic lectures/case discussions and experiential learning, with hands-on laboratory and clinical time incorporated into course content.

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## Hepatitis A: Outbreak Update

Massachusetts continues to experience a significant increase in the number of reported hepatitis A cases. In 2004, 983 cases of hepatitis A were reported to the Massachusetts Department of Public Health (MDPH). This is nearly a four-fold increase from 2003 and nearly a seven-fold increase from 2002. Over the six-year period of 1998 through 2003, the average number of reported cases each year was 209. This increase has occurred statewide.

With Massachusetts still experiencing such high levels of hepatitis A infection, vaccination remains a key intervention. MDPH has promoted hepatitis A vaccination for people at the highest risk. Collaborations among local public health, local health care and community-based agencies has been crucial to this effort. Eligibility guidelines for state-supplied vaccine have been expanded to increase access. Those currently eligible for the state-supplied vaccine include homeless persons; individuals with chronic liver disease, including hepatitis B and C; individuals living with HIV infection; men who have sex with men; and, those who use illicit drugs (both injecting and non-injecting drugs). A complete list is available online at <http://www.mass.gov/dph>.

The Massachusetts Hepatitis Information Line (1-888-443-HEPC) provides information and referrals about all types of hepatitis. It is available 9AM to 9PM Monday through Friday.

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## Emergency Dispensing Sites Guidance

Community-based emergency dispensing sites (EDS) are designed for the administration of vaccines or medications to a large number of people in a short period of time. They may be a necessary part of the response to infectious disease outbreaks of various sizes, ranging from a single case of hepatitis A in a food handler to cases of meningitis in a high school, to an influenza pandemic or bioterrorist (BT) event involving thousands.

Communities in Massachusetts have been asked to identify sites of operation for emergency dispensing by January 31, 2005, and to develop a written plan by June 30, 2005. The time-table meets deliverables for federal funding through the Centers for Disease Control and Prevention (CDC). In a declared emergency, the Massachusetts Department of Public Health (MDPH), working with the Massachusetts Emergency Management Agency (MEMA), will assess and respond to identified local needs for medication.

The objectives for emergency dispensing sites are to be able to meet the needs of the community in a worst-case scenario, which may require the ability to establish a site within 24 hours of notification; to provide initial treatment for 80% of the population within 48 hours; and to provide treatment for the re-

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## Massachusetts HHAN

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labs at high schools, community colleges, military reserve centers, etc., can host HHAN training. If you have a local venue that is available, please contact us and we will arrange a class.

If your computer has a microphone and speakers then we can also provide training through the Internet. Using a product called Interwise, we can help maximize your use of the HHAN without your having to leave your desk. You'll be able to watch as we walk you through everything that the HHAN can do. You can ask questions, draw on our virtual chalkboard and even pass notes to us via the Internet.

Coming soon are interactive HHAN lessons on CD-ROM. Instead of having to repeat a HHAN class if you forgot how to do a particular task (or your skills are rusty), you will be able to load the appropriate lesson and get all of the help that you need via the CD-ROM.

The HHAN team is ready to assist you with what way you need. For more information about scheduled classes, scheduling a local training, Interwise web-based training, or HHAN practical solutions please contact: Scott Kenfield, Massachusetts Department of Public Health, Office of Integrated Surveillance and Informatics Services at [scott.kenfield@state.ma.us](mailto:scott.kenfield@state.ma.us) or (617) 983-6875.

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maintaining 20% over the next 72 hours. This is a large-scale operation requiring multiple agencies and community members. Local EDS plans can be scaled down in response to smaller events.

Depending upon the extent of the event and the geographic distribution of population, communities may choose to establish one or more emergency dispensing site. Although every community must have an EDS plan to provide mass prophylaxis or vaccination, several communities may decide to work together to share resources, enhance efficiencies and create one unified plan.

Communities are encouraged to create planning committees that are representative of all stakeholders. This may include government, schools, public safety, public health, business, special populations and healthcare providers within the community.

The "Emergency Dispensing Sites Management and Operations" (EDS) guidance will be available on the MDPH website. Regional emergency preparedness coordinators are working directly with communities to develop plans utilizing the information detailed in the EDS document.

# Immunization

## Massachusetts Smallpox Preparedness Program

The goal of the Massachusetts Smallpox Preparedness Program is to develop the ability to detect, treat and prevent spread of smallpox. It is part of the Massachusetts Department of Public Health (MDPH) broader emergency preparedness effort intended to maximize the public health system's response to possible bioterrorist acts.

Smallpox was a serious disease that had a major impact on human populations for most of its history. It killed 30-50% of the people who acquired the disease. An unprecedented global effort resulted in eradication of smallpox in the 1970's. Vaccination of the general population ceased in the United States in 1972. Samples of smallpox virus have been stored in laboratories in the US and Russia since eradication. However, there are concerns that infectious virus may have gotten into the hands of organizations, states or terrorists and that the virus could potentially be used as a biological weapon.

MDPH continues in its effort to enhance surveillance and increase education and training concerning smallpox. Vaccination of Smallpox Response Team volunteers continues with 188 volunteers successfully vaccinated to date. An outreach program, focusing on education and training on smallpox vaccination continues. Those trained in smallpox vaccine administration include physicians, dentists, pharmacists, veterinarians, medical reserve corps members, EMTS/Paramedics, as well as public health, school and visiting nurses. To date, 1033 healthcare professionals in Massachusetts have been certified in smallpox vaccine administration. Bioterrorism modular trainings are being offered statewide to enhance smallpox awareness and surveillance potential as well as assist local health departments. Efforts that focus on smallpox awareness also include a general BT agent overview, emergency dispensing site planning, behavioral health emergency planning and an overview of the Health & Homeland Alert Network (HHAN). Each training provides continuing education credit and can be offered separately or together.

Anyone interested in finding out more about being a part of the state's Smallpox Response Team, receiving smallpox vaccination or scheduling bioterrorism trainings should contact Mary Conant BSN, RN, Smallpox Coordinator, Infectious Disease Response Nurse at 617-983-6862 or [mary.conant@state.ma.us](mailto:mary.conant@state.ma.us) for more information.

### Pneumococcal Polysaccharide Vaccine

Remember! Pneumococcal polysaccharide vaccine (PPV 23) is available for all providers and PPV23 can be given year round. For more information, please contact the MIP Vaccine Management Unit at 617-983-6828.

## New Meningococcal Vaccine Requirement for Certain Students in Residential Schools and Colleges

Beginning in August 2005, recently enacted law and related regulations will require that **all new students** at public and private residential schools with grades 9 -12 (in the case of ungraded classrooms, those with students 13 years or older) and new, full- and part-time undergraduate and graduate students in degree-granting programs at postsecondary schools (e.g., colleges) that provide or license housing must:

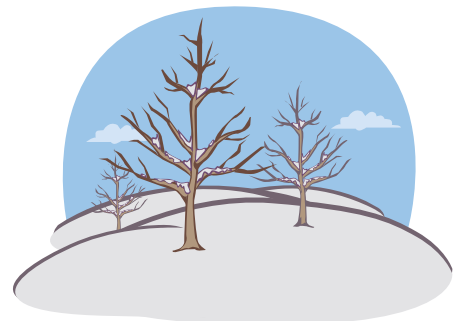
- receive information about meningococcal disease and vaccine, and
- provide documentation of receipt of 1 dose of meningococcal vaccine within the last 5 years (unless the student qualifies for an exemption – see below).

At all affected institutions, these requirements apply to **all new students** regardless of grade, year of study and **whether or not** they reside in school or campus-related housing. Please note at residential schools, the requirements apply to students in lower grades (pre-K through 8) if the school combines these grades in the same school or part of a school with students in grades 9-12.

As an alternative, new students or their parent/legal guardian may sign the Meningococcal Information and Waiver Form developed by MDPH to indicate that they have read and understood the required information related to the risks of meningococcal disease, and have elected to **decline** the vaccine.

Residential schools and colleges that provide or license housing are required to distribute the MDPH-developed waiver, *Information About Meningococcal Disease Vaccination and Waiver for Students at Residential Schools and Colleges*, to all new students.

For more information and to obtain a copy of the information and waiver form, please visit the MDPH Immunization Program Website at [www.mass.gov/dph](http://www.mass.gov/dph) or contact the Massachusetts Immunization Program at (617) 983-6800.



## Perinatal Hepatitis B

The Division of Epidemiology and Immunization Perinatal Hepatitis B Nurse coordinates case management for all babies born to hepatitis B surface antigen (HBsAg)-positive mothers. This ensures that the newborns receive timely and appropriate hepatitis B immunoprophylaxis, and that the mother is counseled regarding reducing the risk of transmitting hepatitis B virus infection to her household and/or sexual contacts. Immunoprophylaxis for the infants consists of administration of hepatitis B immune globulin (HBIG) and the first dose of hepatitis B vaccine at the birth hospital within 12 hours of birth, followed by 2 more doses of hepatitis B vaccine by age 6 months. Infants of HBsAg-positive mothers who do not receive timely hepatitis B prophylaxis are at high risk of becoming chronic hepatitis B carriers. This risk can be reduced by up to 80% with proper case management.

To facilitate identification of HBsAg-positive mothers in Massachusetts, HBsAg-positive women of childbearing age (14-44 years) are reportable by health care providers to the local board of health (105 CMR 300.200). Health care providers and diagnostic laboratories are also encouraged to report these results to the Bureau of Communicable Disease Control's Office of Integrated Surveillance and Informatics Services (ISIS) by confidential fax at 617-983-6813.

### *The Case*

You are a nurse working in the nursery of a large Boston teaching hospital. It is time for you perform a heel stick blood collection on an infant to test for inborn errors of metabolism, and other conditions, then complete the Newborn Screening Specimen Form. One question on the form asks about the birth mother's hepatitis B status. You review the infant's chart and note that the mother tested positive for hepatitis B surface antigen (HBsAg) during her pregnancy. You check the "positive" box on the Newborn Screening Specimen Form.

### **What else should you do?**

#### *Review Hospital Policy and Standing Orders*

Your hospital has a policy of vaccinating all infants with the first dose of hepatitis B vaccine in the hospital, regardless of the mother's HBsAg status. You check the infant's chart and notice that she has not received her first dose of hepatitis B vaccine yet. But you remember something about standing orders for infants born to HBsAg-positive mothers. You check the standing orders at the front of the infant's chart. Sure enough, after the standing orders for vitamin K and antibiotic eye ointment, there it is: an order to administer hepatitis B vaccine and hepatitis B immune globulin (HBIG) within 12 hours of birth to infants born to HBsAg-positive mothers.

#### *Administer Hepatitis B Vaccine and HBIG*

You check the time of birth for the infant, and realize that the infant is 8 hours old. You administer hepatitis B vaccine and HBIG within the next 4 hours and document this on the infant's chart. You also fax a completed Perinatal Hepatitis B Birth Hospital Case Management Form to the Perinatal Hepatitis B Nurse's confidential fax number at 617-983-4380. Once the Perinatal Hepatitis B Nurse receives notification from you that an infant born to a HBsAg-positive mother received the birth dose of hepatitis B vaccine and HBIG in the hospital, it is time for the infant's pediatric provider to become involved in case management.

### **What does the pediatric provider do?**

#### *Administer Vaccine and Determine if Infant is Now Protected*

The pediatric provider ensures that the infant receives the second dose of hepatitis B vaccine at age 1 month, and the third dose at age 6 months, and informs the Perinatal Hepatitis B Nurse of the dates of administration of these vaccines. The pediatric provider will also conduct post-vaccination serologic testing at age 9-15 months for HBsAg and antibody to hepatitis B surface antigen (anti-HBs) to determine whether the hepatitis B vaccination series provided the infant with protection against hepatitis B viral infection.

#### *Serologic Testing Results*

The pediatric provider sends copies of the post-vaccination serologic testing laboratory results to the Perinatal Hepatitis B Nurse. The Perinatal Hepatitis B Nurse analyzes the results and determines one of three outcomes of case management:

1. HBsAg-negative and anti-HBs-positive: The infant is protected from hepatitis B virus and no further case management is needed.
2. HBsAg-positive and anti-HBs-negative or -positive: Infant is infected with hepatitis B virus, and needs to be referred for clinical evaluation and management. No further case management is conducted.
3. HBsAg-negative and anti-HBs-negative: Infant failed to develop protective antibodies from the hepatitis B vaccine, but is not infected with hepatitis B virus. The infant will receive a second 3-dose series of hepatitis B vaccine and be re-tested. If the infant fails to develop protective antibodies again, the mother is counseled on ways to protect her infant from becoming infected with hepatitis B virus. Additional doses of hepatitis B vaccine are not recommended.

# Save the Dates

- March 31 Regional TB Conference - Challenges In TB Management. (Western Region) Topics to be covered: New diagnostic and treatment recommendations; Preventing treatment complications; Unmeasured impact of TB on TB programs; Case presentations; Reading x-rays (for nurses). Call (413) 586-7525 x1127 for more details.
- April 26 10<sup>th</sup> Annual Adult Immunization Conference, Worcester. Visit [www.masspro.org](http://www.masspro.org) for more information.
- May 4 Massachusetts Public Health Association's Annual Celebration and Awards Dinner. 5:30-9:00 pm. Cedars Hall, 61 Rockwood Street, Jamaica Plain. Contact Libby Manly, [Imanly@mphaweb.org](mailto:Imanly@mphaweb.org) or at 617-524-6696
- May 5 MAPHN 8<sup>th</sup> Annual Public Health Nursing Conference, Milford. Visit <http://www.maphn.org/> for more information.
- May 26 Regional TB Conference - Challenges In TB Management. (Southeast Region) Topics to be covered: New diagnostic and treatment recommendations; Preventing treatment complications; Unmeasured impact of TB on TB programs; Case presentations; Reading x-rays (for nurses). Call (508) 977-3559 for more details.
- June 1 Massachusetts State/Local Pandemic Planning Committee, 10:00 - 11:30 AM, State Laboratory Institute, Jamaica Plain. All are welcome. Contact Donna Lazorik at 617-983-6821 or at [donna.lazorik@state.ma.us](mailto:donna.lazorik@state.ma.us) for information.
- June 9 Massachusetts Adult Immunization Coalition meeting. All are welcome. Contact Sheryl Knutsen at 781-419-2749 for more information.
- September 22 Regional TB Conference - Challenges In TB Management. (Northeast Region) Topics to be covered: New diagnostic and treatment recommendations; Preventing treatment complications; Unmeasured impact of TB on TB programs; Case presentations; Reading x-rays (for nurses). Call (978) 851-7261 x4049 for more details.

## Locate Emergency Preparedness Training Online with



**TRAIN-Massachusetts** is a free, web-based learning management system now open for use at [ma.train.org](http://ma.train.org)!

### On TRAIN-Massachusetts you can:

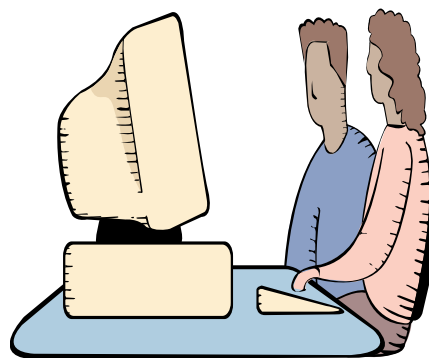
- Browse among hundreds of emergency preparedness training programs
- Register for training programs online
- Launch directly into web-based training programs
- Obtain continuing education credit online
- Maintain a record of the training programs you've completed

**TRAIN-Massachusetts** is intended to provide a single online resource for publicizing emergency preparedness training programs in Massachusetts.

**TRAIN-Massachusetts** is an emergency preparedness initiative developed with federal and state emergency preparedness funds. *It is an initiative that was developed in response to a clear need for a single site for publicizing emergency preparedness training programs.*

Register as a new TRAIN-Massachusetts user at [ma.train.org](http://ma.train.org)!

Questions about TRAIN-Massachusetts? Call Steve Fleming, TRAIN Coordinator, Division of Epidemiology and Immunization, Massachusetts Department of Public Health, at 617/983-6800 or email [stephen.fleming@state.ma.us](mailto:stephen.fleming@state.ma.us).



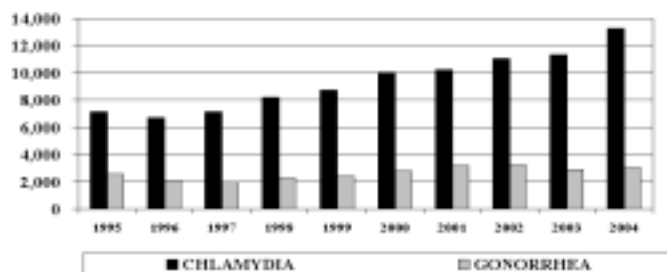
## Sexually Transmitted Disease (STD) Trends in Massachusetts

Preliminary STD data from 2004 indicates that STDs remain a significant public health problem in Massachusetts. Although there has been a decrease in infectious syphilis, there have been increases in chlamydia infection and gonorrhea. Non-Hispanic blacks and Hispanics (who make up 3.4% and 4.1% of the general population, respectively) are disproportionately represented for all reported STDs. Chlamydia infection and gonorrhea are concentrated in people aged 15-24 years, while infectious syphilis is concentrated in people aged 25-39 years.

**Chlamydia** - In 2004 there were 13,275 reported cases of chlamydia infection; the highest number in ten years. This is a 18% increase from 2003, when there were 11,293 cases. The rise in chlamydia cases is associated with more widespread use of more sensitive diagnostic tests and the expanded use of urine-based testing. Improved compliance with STD screening recommendations has been documented for managed care organizations. The female-to-male ratio of reported chlamydia cases in 2004 was approximately 3:1, reflecting the need to improve rates at which male partners of infected women are brought in for screening and treatment. Chlamydia infection was most common in whites (34%) followed by non-Hispanic blacks (32%) and Hispanics (30%). Sixty-eight percent of chlamydia infections were reported in people aged 15-24 years.

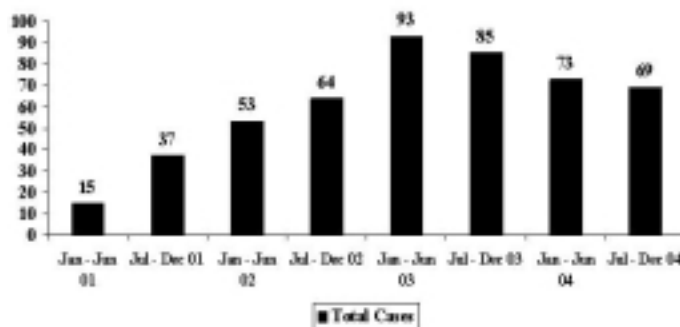
**Gonorrhea** - From 2003 the number of gonorrhea cases increased from 2,873 to 3,047, a 6% increase. This increase was almost entirely in women, in whom gonorrhea increased by 15%, while in men reported gonorrhea decreased by 1%. Non-Hispanic blacks were represented among 43% of the gonorrhea cases, followed by whites (35%) and Hispanics (20%). Teen and young adults aged 15-24 years old accounted for 52% of gonorrhea cases, with people aged 25-39 years old accounting for 35% of the cases. From 2003 to 2004 the number of cases with quinolone-resistant *Neisseria gonorrhoeae* (QRNG) infection increased from 54 to 79, a 46% increase. All of the case of QRNG infection during 2004 were in men who have sex with men (MSM).

Reported Cases of Chlamydia, Gonorrhea, and Syphilis in Massachusetts, 1995 - 2004



**Infectious Syphilis** - The total number of reported infectious primary, secondary, and early latent syphilis cases in 2004 was 208, a decrease of 20% from 2003 when there were 260 cases. This drop is largely attributable to a reduction in cases in MSM, who had experienced a decline from 181 to 142 cases. This reduction is associated with a variety of public health interventions conducted in 2004, including public education campaigns on popular MSM Internet sites, syphilis screening through community-based van initiatives in the South End of Boston, and referrals and advertising of STD clinics through gay bars and the gay press. Infectious syphilis is largely concentrated in people aged 25-39 years old (44%) followed by people aged 40-54 years old (27%).

Reported Cases of Early Syphilis in MSM Massachusetts, July 2001 - December 2004



## STD/HIV Prevention Training Centers Continued from page one

In 2005, training courses will be offered nearly every month throughout the year. All courses are offered free of charge and continuing education credits are provided.

2005 promises to be a busy year for the PTC. In addition to a full training schedule, the PTC will host the annual meeting of the NNPTC in late Spring. The meeting convenes national experts in the field of STD/HIV treatment and prevention. The NNPTC maintains strong collaborative linkages to develop and deliver innovative training and training products to health care professionals throughout the country.

For more information on the National Network of Prevention Training Centers, visit [www.stdhivpreventiontraining.org](http://www.stdhivpreventiontraining.org). To access New England PTC course information, educational resources and/or registration materials, visit [www.state.ma.us/dph/cdc/stdtcmai/stdtcmai.htm](http://www.state.ma.us/dph/cdc/stdtcmai/stdtcmai.htm) or contact the PTC at 617-983-6945.

# Refugee and Immigrant Health

## Health Literacy among Refugees

Health literacy, particularly among refugees, is an important issue for health programs. Inadequate health literacy can cause innumerable health and health care related problems for patients. Most important, is the general adverse relationship of poor reading skills with overall health status and access to care. In addition to specific issues related to access to care, the "Health Literacy Report of the Council on Scientific Affairs" of the American Medical Association identified other crucial areas of health care logistical functioning that are highly literacy-dependent: physician instructions or health messages to patients, informed consent for procedures and research, and preparation for diagnostic studies or procedures.

The 1992 National Adult Literacy Survey is the most accurate large-scale study of literacy in the US. Of those with inadequate literacy, 25% were immigrants; estimated to include up to 11 million immigrants and refugees. Furthermore, declining literacy among young adults was partly attributed to the dramatic increase in young immigrants. Both a lack of schooling and inadequate opportunities for learning English as a second language could explain the worse English literacy among immigrants. While not specific to refugees, the information regarding low literacy among immigrants is compelling, as many refugees typically have unmet health needs that may require adequate literacy, at least in their primary language.

Little is known about the development of English language literacy, and in particular functional health literacy, and its implications for health and health care among refugees. In general, research has supported a strong role for social supports in health literacy and its impact on health status. It has been hypothesized that not only do social support systems (as in the infrastructure of community organization) reduce the adverse effects of low health literacy on health outcomes, but that "functional" social supports (i.e. the receipt of tangible services or assistance) do the same. For example, a refugee who is completely illiterate but has strong social supports within his/her own cultural context, may still be able to utilize health care effectively and achieve adequate health outcomes.

Without social supports, medical care may be compromised, if refugees cannot read or understand English communication (both written and verbal) from health care providers. Medical interpreting may not be routinely used or even available in settings other than major institutions. And even when available, interpreters may not be able to help all patients with specific written care materials or with literacy-dependent tasks outside of the limited time of the clinical encounter. As a result, clinicians in many settings rely on direct communication in English (both verbal and written) with patients.

Physicians are an important source of health information, in addition to giving medical care instructions. There are com-

peting sources of information such as television and the Internet which may not be reliable. Therefore, clinicians and their patients would benefit from a better understanding of the gradations of literacy among the foreign-born and the time-frame for English-language literacy acquisition, as well as how best to utilize low-literacy written English messages and instructions in daily clinical care. In the meantime, clinicians need to be cautious about relying on written care instructions or educational materials with refugees and focus instead on other forms of communication and increased reliance on social supports to facilitate communication.

## Catch-Up Growth in a Severely Malnourished Refugee Population

The Somali Bantu are an ethnic minority who fled civil war in Somalia. Approximately 12,000 have lived in Kenyan refugee camps and are currently being resettled in the US. The Somali Bantu have been severely malnourished during their stay in refugee camps, with worsening of their nutritional status after being relocated prior to resettlement in the US. After undergoing a health screening in the camps for migration processing, Somali Bantu children who were identified as malnourished were enrolled in a therapeutic feeding program.

The Refugee and Immigrant Health Program compared the growth status of Somali Bantu children at the time of their refugee health assessment (conducted shortly after arrival in Massachusetts) with the overseas medical examination in the refugee camp. Overseas measurements were taken in Kakuma refugee camp, to which Somali Bantu were relocated after years in Dadaab, another refugee camp. They were done within one year of departure for the US. Growth measurements were used to determine the extent of both chronic and acute malnutrition among the children. Stunting (excessive short stature) is indicative of chronic malnutrition while wasting (excessive thinness) is indicative of acute malnutrition.

Massachusetts received 123 Somali Bantu child arrivals who completed health screening in 2003-2004. The average age was 6.4 years. On average, the overseas measurements preceded the Massachusetts measurements by 5 months. The measurements were as follows:

Growth Measurements of Somali Bantu Children		
Parameter	Location	
	Africa	MA
% with low weight-for-height (wasting)	32.2	7.6
% with low height-for-age (stunting)	44.9	44.1

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## The Quincy TB Prevention Project: Reaching a High-Risk Population

A Chinese marketplace may seem an unlikely tuberculosis screening site, but recently members of the Division of TB Prevention and Control collaborated with a local health department and a Chinese community organization to bring TB testing and education to a high-risk population. The project demonstrates the value of empowering communities to take an active role in health promotion and disease prevention.

In 2004, 80% of TB cases reported in Massachusetts occurred in the foreign-born (persons born outside the US and its territories), the highest risk group for TB infection and disease. Persons from China accounted for 9% of the total TB cases. The City of Quincy, with its substantial Asian immigrant population, had one of the highest rates of TB in the state last year.

With that in mind, the Quincy Health Department, the Quincy Asian Resources, Inc. (QARI), City of Quincy Outreach and the TB Division gathered to "brainstorm" to find ways to educate this high-risk population about TB and to encourage TB testing. A three-pronged approach was put into effect.

First, a local radio program about TB was recorded. Yin Leung, a TB Division Outreach Educator, spoke in Cantonese about TB, TB medications, the BCG vaccine, and other TB-related issues of importance to the Asian immigrant population on the AM radio station WJDA.

Next, a TB screening and education event was held at the Kam Man Marketplace, an outlet that caters to the Quincy area's Asian community, and includes a grocery, a bank and several independent retail stores. In a collaborative effort: Quincy Health Department nurses, Ruth Jones and Karen McKim, administered TB tests; QARI staff members, Kao Li and Carmen Mei, handled publicity and demographic intake information; City of Quincy Outreach Ombudsman, John Chen, offered interpretive services; and the TB Division provided the education component. Persons who tested positive for latent TB infection were referred to the South Cove Health Center in Quincy or their private provider for follow-up evaluation.

Finally, in a broad-brush attempt to reach a large audience, a cable-access TV spot was recorded. Dr. John Bernardo, Medical Director of the TB Division, and media personality Lola Tom from Quincy Access Television (QATV) channel 8, provided further information about TB infection and disease, TB risk factors and TB medications. Also, Yin Lueng and Carmen Mei discussed the cultural aspects of TB as they pertain to the Chinese population. The program was recorded in English with voice-overs in Cantonese and Mandarin. It was aired regularly throughout the day for one month.

## Tuberculosis Surveillance Areas

To address changing needs for nursing coverage, the Division of Tuberculosis Prevention and Control has reconfigured its Tuberculosis Surveillance Areas (TSAs) from five TSAs to six, and has designated a new North Central region.

The following is a synopsis of the changes: TSA 1 covers western Massachusetts (east to Worcester); the office is located in the Department of Public Health (DPH) Western Regional Health Office in Northampton. TSA 2 covers Metro Boston, which includes Suffolk County (excluding Boston), part of Middlesex County, including the Malden/Medford/Everett area, the greater Framingham area, and a portion of Norfolk County, including Newton/Brookline, and Quincy/Milton. The TSA 2 office is in Canton at the DPH Metro West Regional Health Office. TSA 3 covers the northeast, with staff located at the DPH Northeast Regional Health Office in Tewksbury. TSA 4 is the City of Boston, and TSA 5 includes the southeastern part of the state, including Cape Cod and the Islands of Martha's Vineyard and Nantucket, and the Blackstone Valley communities in southeast central Massachusetts. The TSA 5 office is located in the DPH Southeast Regional Health Office in Taunton. TSA 6 covers North Central Massachusetts, including the Fitchburg/Leominster/Gardner areas and parts of Middlesex County, including the greater Burlington area and Cambridge/Somerville, with staff located at the DPH Northeast Regional Health Office in Tewksbury.

### REGIONAL-BASED RESOURCES:

TSA1 - Central & Western: Josie Ford, RN (temporary)  
(800) 445-1255, Ext. 1127  
Administrative Asst.: Evelyn Thomas

TSA 2 - Metro Boston: Carolyn Harris, RN  
(781) 774-6737  
Administrative Asst.: Debra Thimas

TSA 3 - Northeast: Jo-Ann Keegan, RN  
(978) 851-7261, Ext. 4048  
Administrative Asst.: Connie Parke

TSA 4 - Boston: Boston PH Commission TB Program  
(617) 534-4585

TSA 5 - Southeast, Cape & Islands: Joan Thompson-Allen, RN  
(508) 977-3703  
Administrative Asst.: Sue Feder

TSA 6 - North Central: Joan Powell, RN  
(978) 851-7261, Ext. 4050  
Administrative Asst.: Connie Parke

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## Web Based Training Course Offering

*Partners in Prevention: Infectious Disease Surveillance, Reporting and Control in Massachusetts*

The Massachusetts Department of Public Health (MDPH), Division of Epidemiology and Immunization is pleased to announce a new on-line training course that is fun, easy to navigate, free and offers continuing education credits: *Partners in Prevention: Infectious Disease Surveillance, Reporting and Control in Massachusetts*.

This is an introductory course for persons who are mandated by Massachusetts laws and regulations to participate in infectious disease surveillance and reporting, but may be new to or unfamiliar with their roles and responsibilities.

The course is made up of 5 sections with study questions to help you prepare for the final test. Each section takes about 15 minutes to complete.

Topics include infectious disease surveillance, reporting and control; legal and confidentiality requirements; isolation and quarantine; and infection control measures.

Continuing education credits are available for Physicians, Nurses, Certified Health Officers, Registered Sanitarians and EMT's.

To register for the course, go to **ma.train.org**, register as a new user (if not already a user) and search for the course **Partners in Prevention** among the listings. There is no fee.

## **Somali Bantu** *continued from page seven*

The average increase in weight between screenings was 2.74 kg and the average increase in height was 3.5 cm. While older children were less likely to be acutely malnourished at the time of their health screening both overseas and in Massachusetts, they were more likely to be stunted. Acute malnutrition (wasting) was more common in younger children. Being diagnosed overseas with malnutrition was strongly associated with being both wasted and stunted, indicating that overseas medical staff were effective in identifying malnourished children.

Overseas public health efforts at identifying and correcting acute malnutrition through the therapeutic feeding program appear to have been quite successful as manifested in markedly reduced rates of wasting seen in children arriving in Massachusetts. These rates were comparable to the prevalence of wasting seen in a Somali child refugee population resettled in Massachusetts several years earlier. However, the consequences of chronic malnutrition (e.g. stunting) persisted after migration to the US.

## **Quincy TB Project** *continued from page eight*

The Division of Tuberculosis Prevention and Control congratulates and thanks the City of Quincy, the Quincy Health Department, Quincy Asian Resources, Inc., and Mr. Wan Chu Wu of Kam Man Market for their commitment to the prevention and control of tuberculosis in Massachusetts.



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